SAMPLE

Mental Retardation Community Medicaid Services

____ NEW
FOR CSP YEAR

____ REVISION
FOR CSP YEAR

Agency-Directed Companion Services

INDIVIDUAL SERVICE PLAN

ESTIMATED DURATION:_____ Code # : _____

Individual: _____ Medicaid Number:_____

Provider Name:_____Provider Number:_____

Responsible Staff (name or position of implementer of the plan):_____

Start Date:_____ End Date:_____ Quarterly Review Dates: _____ _____ _____ _____

Goals/objectives are based on up-to-date assessment information present in the file.

CSP SELECTED GOAL/ DESIRED OUTCOME: *To provide non-medical care, socialization or supervision to _____ in the home or various locations in the community.*

OBJECTIVES *(Examples in italics. Complete, revise, delete or add any per individual's needs.)*	TARGET DATE	ACTIVITIES/ STRATEGIES Frequency = _____ X Day *(Examples in italics. Complete, revise, delete or add any per individual's needs.)*
1) _____will receive assistance with a variety of daily activities.		*Staff will provide assistance or support in the following areas (Specify assistance/support provided.)* *Meal Preparation:*_____ _____ *Frequency:* *Laundry:*_____ _____ *Frequency:* *Light Housekeeping:*_____ _____ *Frequency:* *Shopping:* _____ _____ *Frequency:* *Community access and recreational activities:* _____ _____ *Frequency:*

2) _____'s ongoing health and safety will be assured.		*Other:*_____ _____ _____ *Frequency:* *Other:*_____ _____ _____ *Frequency:* *Staff will provide assistance in the following areas (Specify):* *Self-Administration of medication:*_____ _____ *Frequency:* *General support to assure safety:* _____ *Frequency:* *Other:* _____ _____ _____ *Frequency:* *Other:*_____ _____ _____ *Frequency:*

3) *Recommend to CM modifications to ISP as needed, to ensure completion of stated objectives.* 4) *Complete quarterly reviews (summary of services provided and individual's response).* TOTAL HRS PER WEEK:_____		*Forward revised ISP and ISAR to CM for approval PRIOR to implementation.* *Forward to CM as requested no later than _____ working days following the end of the quarter.* *Advise CM, if services were not delivered as scheduled.*

Individual:_____ Service: **AGENCY-DIRECTED COMPANION** Start Date:_____

TOTAL HOURS PER WEEK

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

NOTE: This service is limited to 8 hours/day, including combinations of Agency-Directed Companion and Consumer-Directed Companion services.

COMMENTS:
(Role of other agencies if plan a shared responsibility)

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*